Skilled Nursing Facility Quality Assurance Fee – (FY 06)
Payment For August 1, 2006 To October 31, 2006

Reminder: You MUST select the CLEAR button in order for your information to be erased from this form!

California Department of Health Services
Accounting Section/Cashiers Unit
Mail Stop 1101
1501 Capitol Ave., Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

OSHPD Number: _____
Due Date: **2006/11/29**
Total Remitted: **$**_____

OSHPD No.	Index	Object Detail	Agency Object	BLK	Agency Source	Source	PCA	FFY	Fund
XXXXXXXXX2006	5365	000	00	H	125600	31	85214	B**06**	0001

XXXXXXXXX2006536500000H1256003185214B060001

Skilled Nursing Facility
Quality Assurance Fee Payment Form Rate Year 2006-07

Completion of this form is mandatory.

1. Name of Facility		2. Parent Company, If Applicable	
3. Medi-Cal Provider No.	4. OSHPD No.	5. Facility Telephone Number	6. Facility E-mail Address
7. Facility Street Address		8. City and State	9. Zip Code
10. Mailing Address (if different)		11. City and State	12. Zip Code

CALCULATION OF THE QUALITY ASSURANCE FEE FOR RATE YEAR 2006-07
(August 1, 2006 TO October 31, 2006)

LINE NO.	TYPE OF RESIDENT DAY	NUMBER OF THE FACILITY'S TOTAL RESIDENT DAYS	QAF RATE ASSESSED PER RESIDENT DAY	QAF AMOUNT DUE
1	Medi-Cal Fee-for-Service		$7.79	$0.00
2	Medi-Cal Managed Care		$7.79	$0.00
3	Non Medi-Cal (Private pay, Medicare, HMO, All other)		$7.79	$0.00
4	a) Total resident days (add Lines 1 through 3):	0	b) Total: $	$0.00

Please remit the total amount (Line 4b) along with this form by November 29, 2006 to the address shown above.

I am an administrator, officer or other individual duly authorized and designated to make this certification on behalf of the above named facility. I declare under penalty of perjury under the laws of the State of California that the foregoing information is true, correct and complete.

_____ _____ _____
Original Signature Date Print name & title of person signing declaration Contact phone no.

Print Clear